# Humber NHS Foundation Trust

RV9

# Community health services for adults

## Quality Report

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# Summary of findings

## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| RV9HE | East Riding Community Hospital | East Riding Community Hospital | HU17 0FA |
| RV9X1 | Goole Primary Care Centre | Goole Primary Care Centre | DN14 6RX |

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust

# Summary of findings

## Ratings

| | |
|---|---|
| Overall rating for the service | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Requires improvement |
| Are services well-led? | Requires improvement |

# Summary of findings

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# Summary of findings

## Overall summary

**Overall rating for this core service:** Requires Improvement

We rated services for community adults as requires improvement, because;

- Staffing levels were below established levels throughout many parts of the service.
- Mandatory training compliance was below the trust target levels.
- Safeguarding training compliance was below the trust target levels.
- We found inconsistent practice across teams with regard to record keeping.
- Some Neighbourhood Care Teams did not have access to basic equipment.
- There was no organised clinical audit plan for the service and a lack of audit activity.
- Compliance with Mental Capacity Act training was below trust target levels.
- Mental health records were stored on a separate computer system and community staff told us that this could cause problems in providing care to some patients.
- Some services, such as speech and language therapy and pulmonary rehabilitation, had lengthy waiting times in excess of 18 weeks.
- Neighbourhood Care Teams were not meeting performance targets for triage.
- We saw a lack of evidence to show that learning from complaints was shared across the service.
- Some services did not have a service specification in place.
- Staff told us that they did not always feel part of the wider trust or that there was an awareness in senior leaders of the role of community services.
- Staff told us that they did not feel valued or supported by senior staff.
- We did not see a consistent approach to delivering care between different Neighbourhood Care Teams.
- There was a lack of public and staff engagement in the service.

However;

- Medicines were appropriately managed and stored.
- Staff were able to record and respond appropriately to patient risks.
- The service performed better than the national average in providing harm free care.
- We saw good examples of evidence based practice.
- Staff had access to and underwent regular clinical supervision.
- We saw good examples of MDT working and coordinated care pathways.
- We saw good examples of audits of patient outcomes being monitored in therapy services.
- Patients and families told us that they received compassionate care and that staff supported their emotional needs.
- We saw evidence that patients and families were involved in care planning.
- We observed staff providing compassionate and supportive care in home and in clinic settings.
- We observed staff maintaining the privacy and dignity of patients when providing care.
- Services were planned to meet the needs of the local population, such as the provision of out of hours district nursing.
- Staff were able to account for the needs of people in vulnerable circumstances in delivering care.
- Staff had access to interpretation services.
- Staff valued the support and dedication of their immediate managers.
- We saw good examples of innovative practice.
- All staff we spoke to told us that there was a patient centred culture.

# Background to the service

**Information about the service**

Patients received services in their own homes and in clinic settings from support workers, district nurses, community matrons and therapists. Community teams were part of Neighbourhood Care Teams that worked in partnership between health specialities (such as therapy, community nursing and mental health) and social services. There was also a range of clinics and specialist support in the community offering specialist care for people with long term conditions, specialist rehabilitation (for example, cardiac and pulmonary), podiatry, stroke and pain. Services at the trust were commissioned by separate clinical commissioning groups and were separated between the East Riding and Hull regions. Some teams in the Hull region worked in partnership with another healthcare provider to provide specialist community services in regard to falls, stroke, and rehabilitation.

# Our inspection team

Our inspection team was led by:

**Chair:** Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

**Head of Hospital Inspection:** Jenny Wilkes, CQC

**Team Leaders:** Patti Boden, Inspection Manager, mental health services, CQC;

Cathy Winn, Inspection Manager, community health services, CQC

The team that inspected community adults services included CQC inspectors and community nursing specialists.

# Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

# How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Prior to the inspection we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning group, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations. Before the inspection visit, we reviewed a range of information we hold about these services and asked other organisations to share what they knew.

During our inspection we spoke with 22 patients, five carers, and 75 staff members. We also looked at 36 records, attended eight clinic appointments, and joined services in visiting 16 patients in their own homes.. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the service. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

# What people who use the provider say

Patients and their relatives and carers spoke very positively about the service they received and the support available from staff. Patient complaints did show that some patients were concerned about the length of time they waited for appointments or support. The results of the most recent monthly NHS Friends and Family test for the service showed that for 464 responders, 99% of these were likely to recommend the service as a place to receive care.

# Good practice

- The musculoskeletal physio service had developed a telehealth system that offered direct referral for patients into the service. We observed patients being triaged on the telephone and receiving immediate and advice and support (including via e-mail) to help them begin their rehabilitation.
- The pain service had developed a user support group and was using complimentary therapies, such as Tai Chi, to engage patients in managing their pain. We saw that patient feedback for this service was very positive.
- The community falls service was working in conjunction with the local fire service and health providers to offer joint a rapid response falls assessments service at risk of falls. This was designed to offer clinical support to patients who had been injured in a fall and increase confidence in patients to avoid a fear of falling reducing confidence, independence and social contact.
- The stroke service was working with the Royal Philharmonic Orchestra in the 'Strokestra' initiative. This allowed stroke survivors and their carers to take part in participatory music activities alongside professional musicians, while being supported clinical staff. The aim was to allow patients to work towards physical, emotional, social, cognitive and communicative recovery goals. A live public concert had been arranged for patients to perform their music.

# Areas for improvement

### Action the provider MUST or SHOULD take to improve

The trust must:

- The trust must ensure that there are sufficient numbers of suitably qualified skilled and experienced staff to meet the demands of the service.
- The trust must ensure that accurate, complete and contemporaneous patient records are kept.
- The trust must ensure that staff receive appropriate training, in particular mandatory training, and appraisals as is necessary to enable them to carry out their duties.
- The trust must take action to seek and act on feedback from relevant persons.

The trust should:

- The trust should ensure that Neighbourhood Care Teams have access to basic equipment to enable them to carry out their role.
- The trust should take steps to introduce a formalised clinical audit plan within the service to ensure patient outcomes can be monitored.
- The trust should consider how learning from complaints and incidents is shared across the service.
- The trust should continue work to ensure that service specifications are in place for all areas.

- The trust should take steps to ensure consistent working practices can be embedded between Neighbourhood Care Teams.

Humber NHS Foundation Trust

# Community health services for adults

**Detailed findings from this inspection**

Requires improvement

## Are services safe?

By safe, we mean that people are protected from abuse

**Summary**

We rated safe as requires improvement, because;

- Staffing levels were below established levels and vacancy rates were high throughout parts of the service.
- Mandatory training compliance was below the trust target levels.
- Safeguarding training compliance was below the trust target levels.
- We found inconsistent practice across teams with regard to record keeping.
- Some Neighbourhood Care Teams did not have access to basic equipment.

However;

- Medicines were appropriately managed and stored.
- Staff were able to record and respond appropriately to patient risks.
- The service performed better than the national average in providing harm free care.

**Safety performance**

- The service used the NHS Safety Thermometer to monitor harms to patients under its care. In the period between March 2015 and February 2016, the service recorded 96% harm free care in this period. This was better than the national average of 94%.
- We did not see that safety thermometer information was displayed in community bases for staff and the public to consider when accessing care. Staff also told us that they did not routinely receive feedback about safety thermometer performance.

**Incident reporting, learning and improvement**

- The most recent data from the trust showed that between October 2015 and March 2016 the service reported 572 patient safety incidents. Of these, 408 incidents had been recorded as causing no or minimal harm. The trust had recorded four serious incidents in this period. These related to district or community nursing services and involved falls, pressure care, and issues with transfer or discharge.
- The trust had previously reported two serious incidents within the service in November 2014 and October 2015. These were one grade three and one grade four

pressure ulcer. A standard trust tool for investigating the root cause of pressure ulcers was in use. This ensured that investigators were prompted to consider and assess the relevant clinical evidence. The tool included a template for action planning to learn from incidents. We did not see any evidence that action plans had been completed in the documents we were provided with.

- Staff we spoke to were confident in reporting incidents via the electronic incident reporting system. Staff provided examples of clinical incidents that would be reported, such as drug administration errors and pressure sores. However, they told us that they would not routinely report short staffing concerns.
- The majority of staff we spoke with told us that they did not always receive feedback from incidents to understand how these had been resolved or what lessons had been learnt. We also saw differing practice between teams, with some team meeting minutes outlining discussions around incidents as a standing agenda item, while other teams did not do this.
- The trust operated a 'blue light' e-mail alert that brought attention to trust wide issues and learning from serious incidents. All staff were aware of this and did receive these e-mails. However, there was no provision to share themes or learning from incidents of a lower grade between services. This meant that an opportuning to identify and learn from incident trends was missed.
- We saw examples of staff responding to incidents. One example, was in the home oxygen team where it became apparent that a patient was using incorrect equipment to inhaler the medication. An incident was completed and the appropriate advice and equipment were given.

**Duty of Candour**

- All staff we spoke with were aware of the duty of candour and could explain the principles of being 'open and honest' when incidents occurred. We observed the duty being discussed in team meetings and saw this documented in minutes.
- We saw that serious incident reports for the service included consideration of whether the duty of candour should be engaged and detailed where this had occurred.
- There was an up to date policy in place to provide advice and guidance to staff on the duty of candour process. This included template documentation and flowcharts to assist staff in responding under the duty.
- Staff in community teams were prompted to consider the duty when entering incidents onto the electronic incident reporting system.

**Safeguarding**

- On average, 61% of staff had undergone safeguarding adults training this was worse than the trust's target of 75%. This meant that there was a risk that staff were not appropriately trained to identify and respond to safeguarding concerns.
- Staff that were not up to date told us that they had arranged for training, but had found that sessions were cancelled by the trust. They were unaware of when the next sessions would run at the time of our inspection.
- The trust had an up to date policy in place in regard to safeguarding adults. This included guidance on local safeguarding pathways and contact details. The policy also included information of female genital mutilation. Staff were aware of the policy and this was available via the trust intranet.

**Medicines**

- Medicines were managed appropriately by staff. For the majority of community teams, patient medication was prescribed by their GP or on discharge from hospital. This was stored in the patients home and we saw staff completing appropriate entries in medical records to identify when medicines had been provided.
- In the musculoskeletal physiotherapy service we saw that medications were securely stored and that appropriate checks had taken place to reconcile stock and monitor room temperatures to ensure that medications were safe to use.
- The service made limited use of patient group directions (PGDs). We saw that PGDs were available and signed for medications within the pain and therapy services. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions.
- Staff in the pain clinic made use of a doctor and non-medical prescriber to authorise the use of other medications. Patient specific directives were signed off to allow individual prescribing decisions to be made. Although, staff told us that they would routinely

'secondary prescribe' (i.e. inform the patient's GP of what medication to prescribe) due to limited access to the patient's GP records on the electronic system. This helped to ensure that safe prescribing was practised as the GP could consider the wider medication history.
- Non-medical prescribers we spoke with told us that they received regular clinical supervision in order to allow them to keep up to date with practice. We saw that support was offered from clinical staff within the trust and also via local clinical networks, for example in the specialist nursing service.
- The diabetes team worked in conjunction with the patients GP to request the GP to prescribe a specified diabetes regime.
- During our inspection, we heard of an example of where a drug administration error occurred. We followed this up and saw that an incident form was completed and lessons learnt were identified from the incident and disseminated to staff.

**Environment and equipment**

- The clinic environments we visited were welcoming, with services clearly signposted.
- The trust provided us with an equipment maintenance schedule which identified which pieces of community equipment were in use and when these were to be serviced. The log showed that servicing was up to date.
- Equipment for patients (such as mattresses) were available from a contracted company. All staff told us that they encountered no issues in accessing equipment. This could be delivered within a range of timescales and could be provided on the same day if ordered before 3pm.
- Therapy services had stocks of frequently used equipment on site (such as Zimmer frames) to ensure that these could be provided to patients without delay.
- Within the wound clinic at Neighbourhood Care Team Driffield, we checked the resuscitation equipment available, where a check list was to be completed each day. We checked the list from December 2015 to March 2016 and found only two dates had not been completed.
- Equipment was delivered up to 6pm on the same day when the order was requested before 3pm. Staff could look on the system which identified levels of stock. Nurses were permitted to order profiling beds and any equipment that required to be ordered specifically, was requested and authorised.
- We saw that staff in some Neighbourhood Care Teams that we visited did not have access to all the basic equipment they needed. For example, one service was sharing two thermometers between the whole Neighbourhood Care Team. We saw that the stroke service also did not have a blood glucose monitor. This impacted on the ability of some teams to carry out basic observations.

**Quality of records**

- We reviewed 36 sets of patient records, which represented a sample of the services we visited. The majority of records we reviewed were completed appropriately in line with professional standards, with relevant risk assessments and descriptions of staff interaction with the patient. A minority of records had not been fully completed, for example we saw four records where risk assessments had not been completed and where consent was not clearly documented.
- The trust conducted a regular records audit via an internet survey site. Five records were selected per service and service leads were asked to review them against 22 standard questions covering legibility, risk assessment, and capacity. There was variable compliance in the information we were provided with and the audits did not include details of how shortfalls in practice were to be addressed. We were not provided with any action plans to show how record keeping could be improved as a result of these audits. Some matrons told us that they also performed a 'deep dive' record audit, but were unable to show us details of these or confirm what actions had been taken to learn from any concerns they identified.
- The trust had implemented agile working for community teams. Paper records had been moved from the home of non-palliative patients and staff were expected to complete records on site via their laptop computer.
- We observed varied practice in regard to agile working. One Neighbourhood Care Team we visited were fully agile working, while other Neighbourhood Care Team areas adopted a mix of practices. We observed and were told by some staff that they did not take their laptops on visits and instead completed paper notes to type up later. A minority of staff members told us that they did not take paper notes, but instead inputted records onto the system from memory when they returned to base. In

one example, we were told that it had been four days since a staff member last updated the electronic record. This was raised with the trust during our inspection and they told us that they would take action to look into this matter. This meant that we could not be assured that the trust was routinely keeping accurate and contemporaneous records throughout the service.

**Cleanliness, infection control and hygiene**

- The trust provided copies of infection control audits that took place within the services. The audit asked eight questions around the use of personal protective equipment, hand washing and management of sharps. The majority of audits we reviewed identified no issues in practice. A minority of reports identified a single question where appropriate practice had not been observed (for example, immediately cleaning hands following removal of protective equipment). Where issues were identified it was noted that these were 'discussed at the time' with staff.
- On average, 59% of staff had undergone training in infection control. This was worse than the trust's target of 75%.
- Clinic areas we visited were visibly clean and we saw appropriate use of clinical waste and sharps bins. However, some areas did not have up to date cleaning schedules to identify when cleaning had taken place. This meant we could not be assured that all areas and equipment had been appropriately cleaned on all occasions.
- In general we observed staff demonstrating good infection control techniques in line with trust policies, including hand washing and use of personal protective equipment. We did observe one example of a staff member using a patients washing up bowl to clean a wound in. This was not disinfected before or after use.

**Mandatory training**

- Mandatory training consisted of twelve modules, spanning clinical and non-clinical training (for example equality and diversity, health and safety, infection control and safeguarding). Some modules were available online whilst others required staff to attend face to face training sessions.
- At the time of our inspection, data provided by the trust showed that the service was achieving an overall score of 68% for mandatory training compliance worse than the trust's target of 75%. The majority of staff we spoke with told us that their mandatory training was up to date. This was supported by local records. However, some staff identified issues in booking training and training being cancelled. This meant that not all staff in the service could complete training, due to a lack of available sessions.

**Assessing and responding to patient risk**

- In the majority of cases, we saw that staff carried out appropriate risk assessments at first contact in order to identify patient risk and ensure that care could be tailored to meet these needs. This included basic tissue viability, falls and nutritional assessments.
- However, within Neighbourhood Care Teams the way a patient's care plan and risk assessments were reviewed varied between individuals. We observed that some staff would set up the review as part of a care plan and others set up a task as a reminder to review the care plan or risk assessment. There seemed to be no consistency in the approach taken. This meant that there was a risk that some assessments may not be updated appropriately.
- There was no regular or scheduled handover of patient care in the Neighbourhood Care Teams we visited. Staff told us that formal handovers did not take place to staff arriving later onto shift and that no face to face or telephone handover regularly took place. Staff explained that they would flag to other staff if a patient raised any particular concerns, but this was on a case by case basis. Similarly, no formal handover took place to identify patients of particular concern to the out of hours team.
- We observed the home oxygen team completing a cardio-obstructive pulmonary disorder template on the electronic record to allow a holistic assessment to take place.
- We observed referrals into services being triaged to identify patient risk factors and to determine the priority. This practice varied between teams, for example one Neighbourhood Care Team had a designated Band 6 staff member who reviewed and allocated referrals, whilst another worked to a 'work list' where staff would take cases in accordance with their experience and apparent priority of the referral.
- The service had piloted a Rapid Response service with the long term condition team within the Goole locality. This had allowed Neighbourhood Care Team staff to raise concerns about at risk patients with this team

between 9am and 4pm and to request contact within two hours. The service had ceased on 1 April 2016 due to a lack of funding from commissioners. However, we observed Neighbourhood Care Team members requesting urgent support from the long term conditions team in this area and receiving a patient visit the same morning.

- In a majority of relevant cases, patient risk was identified via risk assessment and that appropriate referrals were made to specialist services for assistance. Examples of this included referrals to tissue viability and speech and language therapy for specialist assistance. Staff told us that the support available from these services varied depending on the geographical area due to the demands on these services.

**Staffing levels and caseload**

- During our previous inspection in 2014, we identified that the trust should review staffing and caseload in Neighbourhood Care Team, to ensure there is a robust, embedded system to determine appropriate staffing and caseload size. We saw that the trust had developed a control system manual to assist in identifying the staffing required for the anticipated number of visits, time taken per contact and percentage of patient contact required per nursing group.
- The trust had utilised a recognised community nursing staffing tool and that regular monitoring of caseload and hours worked was collated. This showed that district nurses were performing an average of 11 visits per day and working 7.5 hours per day.
- At the time of our inspection, seven of the Neighbourhood Care Team areas were operating below the established staffing levels identified by the trust. One serious incident in relation to a grade four pressure ulcer had also identified poor district nursing caseload management as a contributory factor.
- At the time of our inspection, 13 from 30 staff groups had vacancy rates higher that the trust average of 11.6%. In total, the service had 25.83 whole time equivalent (WTE) qualified staff vacancies and 3.6 WTE nursing assistant vacancies.
- Five district nursing teams had qualified nurse vacancy rates above the trust average of 11.6%. The highest of these was the Withernsea team with a rate of 28% (2.3 WTE staff). The Bridlington team had a slightly lower rate at 27.2%, but had a higher number of vacancies at 5.57 WTE staff.
- Two of three physiotherapy teams also had vacancy rates higher than the trust average, with the North Holderness team having a vacancy rate of 50% (0.5 WTE) and Bridlington 33.3% (1 WTE).
- Data provided by the trust showed that as at 23 December 2015, 983 shifts had been covered by bank or agency staff. A further 208 shifts had been unable to be covered by bank or agency staff. Staff in the Neighbourhood Care Teams we spoke with told us that there was limited use of bank or agency staffing. Instead, staff told us that they had been routinely working over hours to accommodate increased demand. This was not formally documented or reported via the electronic reporting system.
- All staff we spoke with told us that they were struggling with work pressures due to a lack of staff and increased numbers of referrals. Staff in focus groups told us that they felt that this impacted on their ability to 'go the extra mile' for patients.

**Managing anticipated risks**

- The trust had a lone worker policy in place. This was out of date at the time of our inspection and had been due for review in July 2015. The policy included risk assessment templates and advised the use of a 'buddy system' for lone working staff. The majority of staff were happy with this system and that it worked for their teams.
- Staff told us that the mobile telephones provided for community workers did not always work and that reception could be poor in more remote areas. Staff felt that this was a risk and that this meant that they could not always comply with the lone worker policy.
- Community services teams managed foreseeable risks and planned for changes in demand due to seasonal fluctuations. Local working instructions were in place for staff in relation to what to do in cases of bad or severe weather. This included contacting case holders, prioritising caseloads and relocating to the nearest base location if staff could not reach their nominated base.
- Staff we spoke with were aware of plans for their service, for example in the event of adverse weather, and were aware of their role in those circumstances.

Good

# Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

**Summary**

We rated effective as good, because;

- We saw good examples of evidence based practice.
- Staff had access to and underwent regular clinical supervision.
- We saw good examples of multidisciplinary team working and coordinated care pathways.
- We saw good examples of audits of patient outcomes being monitored in therapy services.

However;

- There was no organised clinical audit plan for the service and a lack of audit activity.
- Compliance with Mental Capacity Act training was below trust target levels.
- Mental health records were stored on a separate computer system and community staff told us that this could cause problems in providing care to some patients.

**Evidence based care and treatment**

- We saw good examples of staff using evidenced based practice when delivering care to patients. This included reference to relevant national guidelines, such as National Institute for Health and Care Excellence (NICE) guidance for falls, stroke and diabetes.
- The pain service used professional guidance from the British Pain Society.
- Staff in the oxygen service used professional guidance from the British Thoracic Society.
- Staff within the tissue viability service made reference to guidance on the management of leg ulcers issued by the Scottish intercollegiate network.
- Templates and care plans on the electronic record system were linked to evidence bases such as the Marsden Manual (a practice based tool by The Royal Marsden Hospital Manual of Clinical Nursing Procedures).

**Nutrition and hydration**

- The majority of patient records we saw included an assessment of the patient's nutritional requirements. We saw use of the malnutrition universal screening tool (MUST) assessments and observed staff engaging with patients and carers to discuss their nutritional needs.
- We observed three records not including a nutritional assessment. One example was of a palliative patient who was reporting poor nutritional intake who had not been referred for a dietician assessment. We found no record of nutritional assessment or needs recorded in their records.
- The trust had a dedicated dietetics team to provide specialist nutritional and dietician support. At the time of our inspection, the mean waiting time for the service was 60 days. This meant that there was a risk that patients with nutritional needs were not able to access timely support.

**Technology and telemedicine**

- The trust was utilising "store-and-forward", which involved the capturing of clinical information and forwarding it to a specialist clinician. For example, we were told that district nurses would photograph complex wounds, import them into the patient's electronic record, and discuss their patient with the tissue viability service.
- The smoking cessation service offered telephone based advice and a text reminder service of appointments.
- The physio direct service allowed patients to self-refer to physiotherapy via telephone. Staff would then call patients back and triage their needs, before providing appropriate advice or clinic appointments to further their care.
- Staff had developed multi-media tools to assist patients. Examples included, staff in the pulmonary rehab service had developed a relaxation CD for patients and staff in the respiratory service had developed a DVD to highlight the services which they offered.

**Patient outcomes**

- During our previous inspection we identified that the trust should improve the clinical audit programme to

include community health care services. At the time of our inspection, we saw some limited examples of patient audit taking place. This included audits in pulmonary rehab, stroke and some Neighbourhood Care Teams.

- Senior staff we spoke with explained that there was no formalised clinical audit plan for Neighbourhood Care Teams or some therapy services. Senior staff also explained that there often was not time for audit activity to take place.
- Therapy services collated outcome data using the Therapy Outcome Measure System. This was able to track the extent to which a patient's health improved following therapy intervention. We saw that this was recorded in the electronic record system.
- The chronic pain service had produced its own patient questionnaire and had collected information to show patient satisfaction within its service. The questionnaires we reviewed all identified that patients had a positive experience of the service.
- The national diabetic foot audit identified that the trust was performing better than the national average for patients seen within two days of referral (21.3% against 14.14%) and the percentage of patients who were ulcer free at 12 weeks (51.1% against 48%).

**Competent staff**

- Newly appointed staff underwent an induction process. They told us that they found this process helpful and were well supported by colleagues during this process.
- On average, data provided by the trust showed that 54% of non-medical staff had undergone an appraisal in the last 12 months worse than the trust's target of 75%.
- The majority of staff we spoke with told us that they had an up to date appraisal. Staff described the process as useful and that they were able to input into goal and objective setting.
- The trust told us that they would expect all clinical staff to have supervision every four to six weeks (10 supervision sessions per annum). However, there was not a compliance target at the time of our inspection. Data provided by the trust showed that an average of 67% of staff had undergone clinical supervision between July and December 2015.
- During our inspection we saw that staff did have access to regular supervision. This occurred in team meetings and in one to one sessions. These were recorded in staff development folders and we saw evidence of clinical discussions taking place within team meetings.
- Staff told us they received training through a variety of sources, including professional qualifications and in-house training. We saw evidence of staff members being supported to pursue these qualifications and that they were supported by the trust in doing so.
- We saw that specialist staff within the service delivered training to other staff to increase their knowledge and competence in areas such as oxygen therapy and diabetes. An example of this was that once a month the diabetes team provided a teaching session to all staff for the administration of insulin and diabetes overview. However, at the time of our inspection the last training session had been cancelled due to staff shortages.

**Multi-disciplinary working and coordinated care pathways**

- We saw good examples of MDT working during our inspection. In particular, the nature of the Neighbourhood Care Teams meant that staff were arranged within MDT teams in specific geographical areas. We saw examples of staff interacting, both formally and informally, to discuss patients care between teams and seek advice from colleagues.
- The trust had prepared a formal report on MDT working which included guidance to staff on effective MDT working and the standards expected. We also saw that some services had undertaken process mapping exercises to identify the care pathway and where joint working was required with other services, this included the pain service and musculoskeletal physiotherapy.
- We saw records of MDT meetings taking place within the community falls service. This included joint working with teams such as the pain service, physiotherapy and pharmacy.
- The respiratory service held a weekly team meeting with the respiratory medical registrar. Within the meeting complex patients and their care would be discussed.
- The diabetes teams met with the Neighbourhood Care Team they were aligned with every month to discuss complex patients and review the patients on insulin therapy.

Good

# Are services effective?

- The East Riding Stroke service was working with the local trust stroke service to develop a standardised protocol for referral for driving assessment.
- The pain team in the East Riding included a leisure therapy specialist from the local authority to allow a co-ordinated pathway for patients to access leisure services to assist in pain management.

**Referral, transfer, discharge and transition**

- Patients were referred into the Neighbourhood Care Team via a single point of access. This allowed new patients to be referred electronically into a centralised system and then for these referrals to be passed to the relevant team. In Hull, the service had entered into partnership with a local healthcare organisation and their centralised point of access was used for patients in that area.
- Local single points of access were also available within each geographical area. Staff explained that this was to allow follow up patients a local point of contact to re-refer into services when they had additional care needs following discharge.
- Referrals could then be 'tasked' to teams under the trust's electronic patient record system. This allowed teams to track incoming work and prioritise their caseload.
- Referral into other services (for example pain clinic) were via paper referral from a GP or other care provider. These were faxed or posted to services and then added to the waiting list following triage.
- Referral criteria were in place for specialist services, such as pulmonary rehabilitation and diabetes. Staff in the diabetes service also told us that they were part of a working group to improve the quality of information provided in referrals to the service.
- Requests for support from other services within the trust could be made via 'tasking' items within the electronic record system. We observed examples of this in practice with the district nursing and long term condition nursing teams. This allowed staff to easily request support from colleagues.
- The majority of GP services within the area shared the trust's electronic record system. This allowed patients to be 'tasked' back to GP care on discharge. GPs not on the system received paper copy discharge information.
- The musculoskeletal physiotherapy service offered direct referral for patients via its telemedicine service.

**Access to information**

- The trust used an electronic record system throughout the community services. This allowed a single point of access to records for staff. The trust did use a separate record system for mental health records. Staff in some services, for example pain clinic, told us that this could be a problem as they could not access information about a patients mental health needs that could assist them in their work.
- Staff could use the trust electronic record system to access care information from other services when patients had indicated that they were happy for this to be shared. This allowed instant access to staff to see the range of care delivered to a patient.
- Some staff in the service described that GP services using the electronic system could be 'tasked' in order to forward patient care details and information about patient needs.
- Staff could access a range of trust policies and guidance via the trust intranet.

**Consent, Mental Capacity act and Deprivation of Liberty Safeguards (DoLS)**

- The overall compliance rate for Mental Capacity Act training in the service was 56%; worse than the trust's target of 75%. This meant that there was a risk that staff were not sufficiently trained in identifying patient capacity.
- However, the majority of staff we spoke with were able to provide assurance around their understanding of mental capacity and practical examples of how this would be assessed, or any concerns escalated.
- The trust had an up to date policy in place to provide staff with guidance on gaining consent and the MCA. There was also an up to date policy in place to advise staff on the use of DOLS.
- We observed consent being taken from patients before clinical interventions took place and saw that this was recorded appropriately in the records we reviewed.

Good

# Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

**Summary**

We rated caring as good, because:

- Patients and families told us that they received compassionate care and that staff supported their emotional needs.
- We saw evidence that patients and families were involved in care planning.
- We observed staff providing compassionate and supportive care in homes and in clinic settings.
- We observed staff maintaining the privacy and dignity of patients when providing care.

**Compassionate care**

- All patients and relatives spoke highly of the care they received both at home and when visiting the clinic. Patients described staff as being very helpful and supportive of their needs.
- We observed staff interacting with patients in clinics and at appointments in a caring and compassionate manner. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We observed that staff respected the privacy and dignity of patients. Staff were sensitive in the way they discussed aspects of the patient's care with them in order to preserve confidentiality in clinic and in home settings. Staff asked patients their preferences as to persons observing clinic interactions and sought consent to share details of medical records with other professionals.
- The majority of services told us that they relied on the NHS Friends and Family test results to monitor patient outcomes. Trust wide data showed that patients' recommending the trust as a place to receive treatment in the NHS friends and family test, was above the England average during the six-month period from July to December 2015. However, the response rate was lower in each month (around a third) of the England average.
- The most recent data for community adult services showed that of 464 responders, 99% of these were likely to recommend the service as a place to receive care. This was above the England average of 95%.

**Understanding and involvement of patients and those close to them**

- We saw that staff gave a full explanation of the care and treatment the patient was receiving when discussing matters with them in clinic and at home. The majority of care plans we saw were patient focused and involved families and carers where appropriate.
- Patients we observed felt involved in their care and described being included in decision making about the treatments they received. The patients understood what was to happen in terms of outcomes and how to contact services in times of additional need.
- We observed a gym session with a physiotherapy patient. The patient was engaged in the session, with full explanations provided around the purpose of the exercises being performed. Through discussion with the patient, this was linked to the practical benefit the patient would see in their own daily activities in order to provide encouragement and support in completing the programme.
- We saw that staff within the community falls service worked closely with care home activity supervisors and patients to ensure that there was an understanding of the care a patient was receiving and to ensure that the patient and carers were engaged in achieving their goals.
- Some services ran educational and support groups to assist patients in taking an ownership and understanding of their health needs. This included educational or support sessions by the stroke, diabetes and pain service.

**Emotional support**

- Patients, families and carers told us that they felt they received good emotional support from staff.
- We heard good examples of staff providing additional emotional support to patients. For example, one allied health professional had made themselves available to attend a benefits meeting with a patient at their request. This was due to the supportive relationship built up between the patient and the staff member.

Good

# Are services caring?

- The community nursing service offered bereavement visits to families of patients following their death. Staff explained that this could take the form of personal visits or telephone contact depending on the wishes of the family.
- As Neighbourhood Care Teams also incorporated adult mental health services, community staff explained that they could easily access support, guidance and referral for patients who may have additional emotional or psychological needs.
- The pain service facilitated a patient group that allowed patients to meet and discuss the challenges they faced in a supportive environment.

Requires improvement

# Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

**Summary**

We rated responsive as requires improvement, because;

- Some services, such as speech and language therapy and pulmonary rehabilitation, had lengthy waiting times in excess of 18 weeks.
- Neighbourhood Care Teams were not meeting performance targets for triage.
- We saw a lack of evidence to show that learning from complaints was shared across the service.
- Some services did not have a service specification in place.

However;

- Services were planned to meet the needs of the local population, such as the provision of out of hours district nursing.
- Staff were able to account for the needs of people in vulnerable circumstances in delivering care.
- Staff had access to interpretation services.

**Planning and delivering services which meet people's needs**

- Neighbourhood Care Teams allowed some core community services to be placed together within a geographical region. This allowed staff and patients easy access to professionals within district nursing, therapy and mental health services (if required).
- Services were delivered in a range of community locations and bases. This allowed patients a choice of where to attend for appointments for a majority of services, including podiatry and therapy services.
- We saw that Neighbourhood Care Teams and the community falls service had specialist teams that engaged with care homes within their areas. This allowed services to be tailored to the specific demands of care home patients and allowed the trust to meet the needs of staff and families in these settings.
- In Bridlington the prevalence of cardio-obstructive pulmonary disease was three times more than the national average. In response to this, the pulmonary rehab service ran a clinic permanently at this venue two times a week. In addition, the service had trialled different times of clinics in response to patient needs. For example, a late morning clinic was tested due to poor uptake in the early morning clinic.
- During our last inspection we identified that the trust should continue to work with commissioners to ensure that all its services had up to date service specifications to ensure that staff and the public knew what should be provided. At the time of our inspection, the trust confirmed that dietetic, speech and language, stroke and diabetes services in the East Riding had yet to have service specifications confirmed. The trust explained that this was due to local procurement processes and that the local clinical commissioning group was engaged in producing up to date service specifications for these services.

**Equality and diversity**

- The trust had a corporate policy in place for interpretation and translation. The policy identified how to access both telephone and face to face interpretation, both during and out of hours.
- The majority of staff we spoke with were aware of how to access interpreter services and provided examples of doing so. A minority of staff told us that they had relied on family members to assist in interpretation when required. This was not always appropriate and safeguards against this were set out in the corporate policy.
- We saw no leaflets or information available for non-English speakers in the clinics we visited. The corporate policy did indicate that leaflets and information in alternate languages were available centrally from the trust.
- Equality and diversity training within the service was at 49% against a trust target of 75%.

**Meeting the needs of people in vulnerable circumstances**

- Staff within the service told us that they used the 'butterfly scheme' to help identify patients with dementia and ensure care could be tailored to their needs. This is a national scheme that teaches staff to

offer a positive and appropriate response to people with memory impairment and allows patients with dementia, confusion or forgetfulness to request that response via a discreet butterfly symbol on their notes.
- Where paper notes were not in use, the electronic record system had the ability for pop up notes to be provided when staff accessed the patient record. We saw that this was used to help flag to staff patients who may require additional support or adaptations in their care, for example patients with dementia or patients with communication needs.
- The trust provided details of joint working arrangements which were in place between the community team for learning disabilities and community health services such as district nursing and falls teams. This allowed community staff to access specialist support.
- A physiotherapist from the learning disability service had taken up post in the community respiratory team to offer additional support for patients with additional needs.
- The trust had developed the Pocklington health and social care hub. This partnership with primary care, local authority and voluntary services focused on supporting service users to manage their conditions at home and become more independent. It offered support to frail, elderly and vulnerable older people to enable them to be active and independent in their own home and to provide a multi-agency response when a crisis occurs.

**Access to the right care at the right time**

- The trust provided data to show the mean average number of days from referral to assessment for a number of specialties. On average, patients waiting a mean time of 16 days for assessment by the Neighbourhood Care Team, 24 days for physiotherapy, and 36 days for podiatry.
- The trust collated performance data on the Neighbourhood Care Team service this identified 100% targets for contact timescales. Data showed that the service was failing to meet these targets during the latest quarter, with average performance for clinical triage of routine referrals within one day at 62%, urgent referrals to be triaged and contacted within four hours at 40%, and a telephone response within four hours to contact from local NHS trust bed bureaus or assessment units at 21%.
- Urgent referrals were triaged and we observed examples of Neighbourhood Care Team and specialist nursing services being able to respond to urgent referrals on the same day.
- District nursing services had been extended to run from 8am until 10pm on weekdays. This meant that patients could still access their local district nursing team within these hours. Outside of these hours and out of hours nursing team was available. This was located centrally within the trust's geographical area, in Beverley.
- The trust provided data to show the response times for out of hours district nursing contacts. The trust target was for 100% of urgent contacts to be actioned within 4 hours of referral. Between quarter one and the time of our inspection, the trust averaged 80.3% of contacts actioned within this timescale.
- The trust provided data on average waiting times for therapy patients (for example, speech and language, physiotherapy, podiatry and speech and language). However, the data provided did not specify the targets for the service to benchmark the data against.
- The trust had a target of 90% of patients to begin pulmonary rehabilitation within 10 weeks. Data provided by the trust from April to October 2015 showed that an average of 28.5% of patients began treatment within this timescale with the average waiting time being approximately 56 weeks.
- At the time of our inspection, data from the trust identified that the average wait for pulmonary rehabilitation was 306 days. The service report we received did not contain this data, but this was corroborated by a local report we obtained during the inspection. This identified that at the time of our inspection 45% of pulmonary rehabilitation were waiting more than 18 weeks for an appointment, with 12% (27 patients) having waited more than 52 weeks for an appointment.
- The East Riding speech and language therapy service also provided data to show that the average waiting time for an assessment was 26 weeks at the time of our inspection.
- At the time of our inspection, patients were being triaged by the home oxygen team within 24 hours and were seen within four hours of triage for the initiation of oxygen. There was no waiting list for the home oxygen service.

Requires improvement

# Are services responsive to people's needs?

- We saw that Neighbourhood Care Teams had reduced the percentage of patients not attending/cancelled appointments or failed visits to within the 2% target set by the trust.
- The diabetes team waiting list has reduced from 135 patients to 11 by staff actively reviewing the referrals received and contacting patients to identify what they required from the service. The team contact patients by letter requesting them to contact the service and could then ensure that they could tailor care to meet their individual needs.
- The physiotherapy service operated a system to request patients confirm their appointments. A letter was sent to the patient with a provisional appointment and the patient had to confirm acceptance by telephone within two weeks. If they did not do so, they were taken off the list. Staff within the service told us that this had reduced the number of cancellations and missed appointments.

**Learning from complaints and concerns**

- Between January and December 2015, the service received 25 complaints with 11 upheld and four partially upheld. The main issues identified in complaints were in relation to delays in appointments/treatment and the attitude of staff.
- Staff we spoke with were aware of the complaint process and how they could raise concerns with the complaints team.
- We saw limited examples of complaints or concerns being discussed at team meetings. Staff we spoke with were not always aware of learning from complaints or how this was embedded to learn and improve practice throughout the services.
- We saw examples of local learning from complaints. For example, a complaint was received regarding the pulmonary rehab clinic, which was held in a gym. The patient complained that they could hear another patients conversation. As a result the clinic changed its approach to communicating with patients in the gym to ensure patient confidentiality was maintained.
- Patients we spoke with told us that they would be comfortable raising concerns with staff. However, we saw limited information displayed in clinical areas (such as posters or leaflets) setting out the complaint process and explaining to patients how they could raise concerns. The Trust told us that information was available to patients via patient information leaflets and appointment letters.

Requires improvement

# Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

**Summary**

We rated well-led as requires improvement, because;

- Staff told us that they did not always feel part of the wider trust or that there was an awareness in senior leaders of the role of community services.
- Staff told us that they did not feel valued or supported by senior staff.
- We did not see a consistent approach to delivering care between different Neighbourhood Care Teams.
- There was a lack of public and staff engagement in the service.

However;

- Staff valued the support and dedication of their immediate managers.
- We saw good examples of innovative practice.
- All staff we spoke to told us that there was a patient centred culture.

**Service vision and strategy**

- The trust's vision was to be the leading provider of integrated health services, recognised for the care, compassion and commitment of our staff; a trusted provider of local healthcare; great place to work; and a valued partner with a problem solving approach. This was accompanied by five values including acting with compassion, putting others first and continually improving.
- Some services we visited had produced local 'vision' statements. These had been prepared by staff to describe the service and the aim of the care they provided. Examples of this included some Neighbourhood Care Teams and the community falls service. The vision statements we saw broadly aligned with the trust vision to put patients first and seek to provide high quality care, in collaboration with the patients.
- We saw that the trust's vision and values were displayed on posters in staff areas we visited. The majority of staff we spoke with were aware of the wider principles of the trust's vision and values.
- Staff within the service told us that they did not feel that the trust vision or values were always reflected in the treatment of community services and staff within these services. Staff felt that community services were not always a valued part of the trust and that there was no specific vision for the community services as a whole and how this was incorporated into the wider trust.

**Governance, risk management and quality measurement**

- The service used a local governance assurance framework (Minding the Gap). This was a structured approach to providing governance across the care group and included provision for local team meetings, locality governance groups, and care group level meetings. The outcomes of these meetings were then fed into board level meetings by the appropriate directors.
- We saw evidence of team meetings taking place within the services. A standard template had recently been developed with standing agenda items for teams to consider. The trust provided a copy of the service risk register from December 2015. This detailed nine local risks by care group.
- The highest rated risks related to waiting times for East Riding physiotherapy, increased complexity of patients into the Neighbourhood Care Team and the impact on waiting times, and the need for the East Riding stroke team to deliver specialist support across the whole of the East Riding. There was limited evidence that appropriate control measures were in place and being actively monitored.

**Leadership of this service**

- Clear leadership structures were in place within teams with identified service leads, matrons, or clinical leads as appropriate. We saw that leadership team meetings took place and that information from these meetings was cascaded to staff via team meetings.
- The majority of staff we spoke with, spoke highly of their immediate line management at Band 7 and 8 levels. The majority of staff we spoke with felt supported within their teams by their managers.

Requires improvement

# Are services well-led?

- The majority of staff told us that they did not feel supported or valued by more senior managers. Staff told us that they did not feel that senior staff were visible and that there was poor understanding at senior levels of the demands on staff working in physical health care settings.

**Culture within this service**

- Staff described a supportive culture within their immediate teams and were working beyond their planned hours on occasion to complete work tasks. Staff described the need to do this to ensure patient care remained at an appropriate level.
- Staff told us that they felt under pressure due to increasing workloads and a lack of staff. This was supported with nursing teams having higher than average sickness absence. For example, district nurse teams in Beverley (11.6%), Bridlington (13.3%) and North Holderness (17.3%) had absences well above the trust average of 5%.
- There was limited examples of a shared culture between some Neighbourhood Care Team areas. Areas that were not under the same community matron had little contact with other teams and we saw varied manners of working and cultural attitudes. Staff told us that no regular meetings or events were available for teams to share culture and learning.
- Some specialist teams did have meetings between areas and explained that these were helpful to them. Examples of this included occupational therapy teams and some specialist nurse services.
- All staff described the patient and the satisfaction from their work as the best thing about their role. Staff were patient focused, but reflected that they would like more time per patient contact in order to provide the best level of care.

**Public engagement**

- Staff we spoke with were not aware of any active programmes to engage the public in decisions about how services were provided.
- The trust provided us with details of 'world café' events hosted in local communities to provide the public with opportunities to comment on trust services. The last event was held in July 2015, and involved community adult services. We were not provided with details of any outcomes or impacts on services as a result of these events.
- The health trainer service had a formalised plan of public and trust engagement events. This included health promotion events covering a range of needs, from stop smoking to change 4 life, at a range of community centres, including GP practices, local halls, and supermarkets.

**Staff engagement**

- The majority of staff we spoke with told us that they did not feel engaged by the trust in reaching decisions around the service. Staff described how decisions 'happened to them' rather than having their views accounted for when changes were made. Examples of this included staff being critical of the consultation process that took place surrounding the change in district nursing working hours and reallocation of staff following a change in care group structures.
- Staff told us that they did receive a weekly e-mail from the chief executive with information about the current trust news and events. The majority of staff in the service felt that this was often not relevant to them as it mainly covered mental health news and issues.

**Innovation, improvement and sustainability**

- The pain service offered Tai Chi clinics to patients to provide an alternative method of controlling pain and improving mobility. We observed a clinic session and saw positive feedback from patients about the benefits of the treatment.
- The community falls service was working in conjunction with the local fire service and health providers to offer joint a rapid response falls assessments service at risk of falls. This was designed to offer clinical support to patients who had been injured in a fall and increase confidence in patients to avoid a fear of falling reducing confidence, independence and social contact.
- The stroke service was working with the Royal Philharmonic Orchestra in the 'Strokestra' initiative. This allowed stroke survivors and their carers to take part in participatory music activities alongside professional musicians, while being supported by clinical staff. The aim was to allow patients to work towards physical, emotional, social, cognitive and communicative recovery goals. A live public concert had been arranged for patients to perform their music.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider must ensure that accurate, complete and contemporaneous patient records are kept.<br><br>How the regulation was not being met:<br><br>We observed differing practice between team in regard to record keeping. This included some medical records not being completed contemporaneously at or near the time of patient interactions. There was a lack of a robust audit system for records.<br><br>This was a breach of Regulation 17(2)(c). |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>How the regulation was not being met:<br><br>There was limited evidence of staff or public engagement within the service. There was no structured survey programme to seek patient feedback. Staff told us that they did not feel engaged in decisions about the service.<br><br>This was a breach of Regulation 17 (2)(e). |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider must ensure that there are sufficient numbers of suitably qualified skilled and experienced staff to meet the demands of the service.<br><br>How the regulation was not being met:<br><br>Staff levels were below establishment levels set by the trust and staffing was impacting on team targets not always being met.<br><br>This was a breach of Regulation 18(1). |
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>The provider must ensure that the persons employed by the services receive such support training, professional development, supervision and appraisal necessary to enable them to carry out the duties they are employed to perform.<br><br>How the regulation was not being met:<br><br>Staff were below the trust target of 75-80% in their mandatory training in most areas.<br><br>This was a breach of Regulation 18(2)(a). |